S. No. 300
v. 10.48

26

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2872

State File No. 148

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST LOUIS
c. LENGTH OF STAY (In this place): 40 YRS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2801 S. BROADWAY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO.
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
d. STREET ADDRESS (If rural, give location): 2801 S. BROADWAY

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): KARGACIN
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): JAN - 5 - 1949

5. SEX: M.
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): ✓
8. DATE OF BIRTH: OCTOBER 9 1883
9. AGE (In years last birthday): 65 YR. IF UNDER 1 YEAR: Months ? Days ? IF UNDER 24 HRS.: Hours ? Min. ?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Jugo SLAVIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: MATT
13b. MOTHER'S MAIDEN NAME: Osla MARich
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: TERZA KARGACIN
ADDRESS: 2628 CAROLINE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Chronic Myocarditis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): decompensated Cirrhosis

DUE TO (c): of Liver

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): St Louis Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 7:20 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Alfred Perry Deputy Coroner
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 1/7/49

24a. BURIAL, CREMATION, REMOVAL (Specify):
24b. DATE: JAN-7-49
24c. NAME OF CEMETERY ~~OR CREMATORY~~: ST. MATTHEWS CEM.
24d. LOCATION (City, town, or county) (State): ST. LOUIS MO

DATE REC'D BY LOCAL REG.: JAN 7 1949
REGISTRAR'S SIGNATURE: Jos B. Laraten
25. FUNERAL DIRECTOR'S SIGNATURE: E. J. Schnur
ADDRESS: 3125 Lafayette.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Student Embalmer No. ....., working under my personal supervision.

Signed Jos B Vollmer

Signed .....
Student Embalmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.